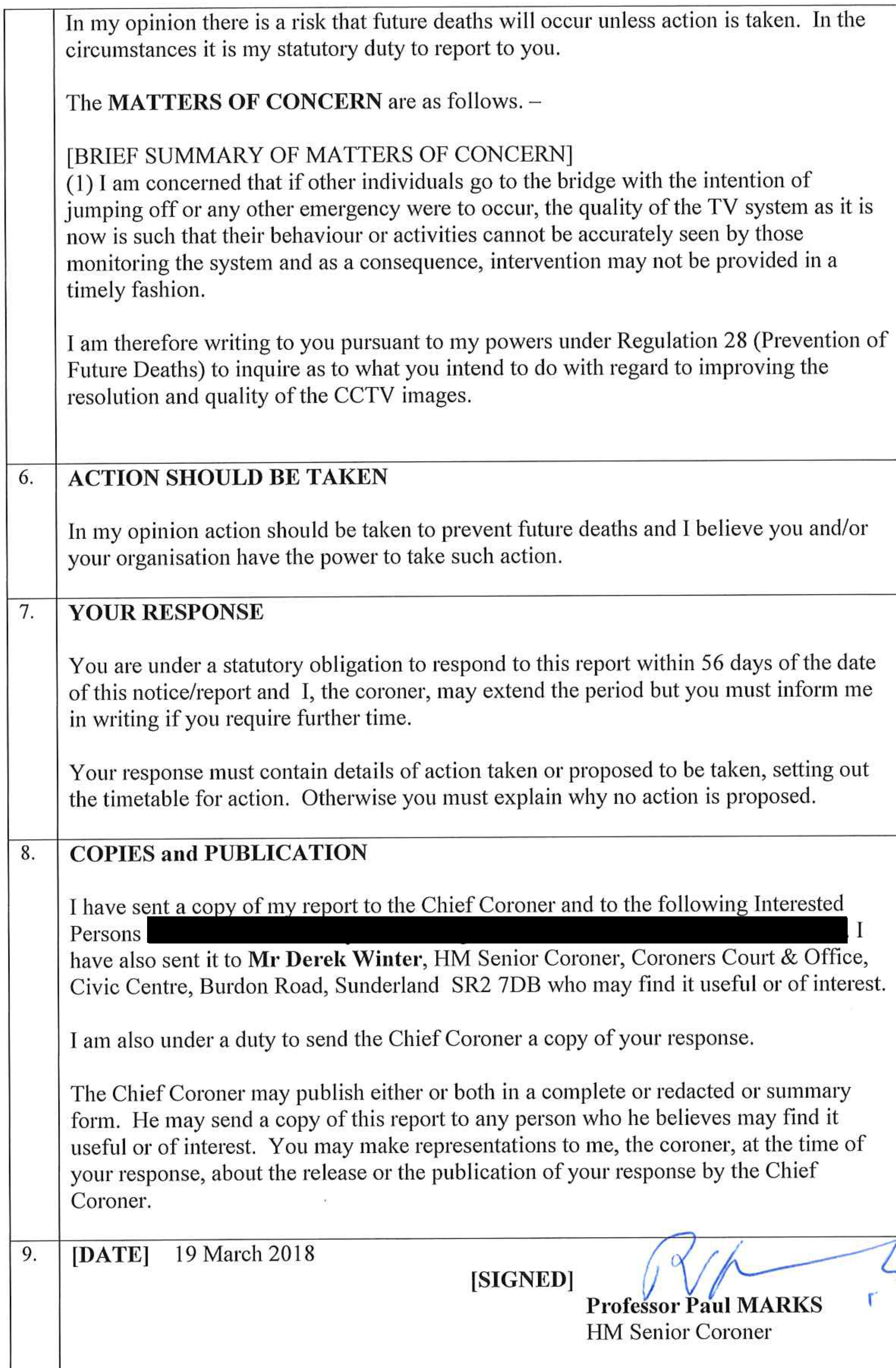
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Head of Operations, Humber Bridge Board, Ferriby Road, Hessle, East Yorkshire HU13 0JG
1.	**CORONER** I am **Professor Paul MARKS** BA LLM MD FRCS, Senior Coroner for the coroner area of East Riding and Kingston upon Hull
2.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 7th September 2017, I commenced an investigation into the death of **Kellie Marie TAYLOR** formerly known as **Kellie Marie DANVILLE.** The investigation concluded at the end of the inquest on the **5th of March 2018**. The conclusion of the inquest was **SUICIDE. Kellie Marie TAYLOR** formerly known **Kellie Marie DANVILLE** was pronounced deceased within the Humber Rescue Boathouse Hessle Foreshore, Hessle on the 4th September 2017. The cause of her death was due to massive intra-abdominal haemorrhage, consequent to traumatic splenic rupture which ensued as a result of a fall from height.
4.	**CIRCUMSTANCES OF THE DEATH** She jumped from the Humber Bridge into the river below and died as a result of Ia) Massive intra-abdominal haemorrhage Ib) Splenic rupture Ic) Fall from height II) Lung contusions with haemorrhage
5.	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Evidence was heard that the close circuit television monitoring system on the bridge was of poor quality and this has been known for some time. The significance of this is that the precise sequence of events of Kellie leaving the car from which she was travelling in to her getting to the parapet of the bridge was not accurately visulaised due to the poor resolution of the system.



	In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) I am concerned that if other individuals go to the bridge with the intention of jumping off or any other emergency were to occur, the quality of the TV system as it is now is such that their behaviour or activities cannot be accurately seen by those monitoring the system and as a consequence, intervention may not be provided in a timely fashion. I am therefore writing to you pursuant to my powers under Regulation 28 (Prevention of Future Deaths) to inquire as to what you intend to do with regard to improving the resolution and quality of the CCTV images.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7.	**YOUR RESPONSE** You are under a statutory obligation to respond to this report within 56 days of the date of this notice/report and I, the coroner, may extend the period but you must inform me in writing if you require further time. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8.	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons I have also sent it to **Mr Derek Winter**, HM Senior Coroner, Coroners Court & Office, Civic Centre, Burdon Road, Sunderland SR2 7DB who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9.	**[DATE]** 19 March 2018 **[SIGNED]** **Professor Paul MARKS** HM Senior Coroner